

**South Carolina**  
**Department of Health and Human Services**  
***Electronic Funds Transfer (EFT) Authorization Agreement***

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**PROVIDER INFORMATION**

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Provider Name \_\_\_\_\_

Medicaid Provider Number \_\_\_\_\_

Provider NPI Number \_\_\_\_\_

Provider Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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**BANKING INFORMATION** (Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).

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Financial Institution Name \_\_\_\_\_

Financial Institution Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Routing Number (nine digit) \_\_\_\_\_

Account Number \_\_\_\_\_

Type of Account (check one)    ☐ Checking    ☐ Savings

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.

I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signed \_\_\_\_\_ (Signature)  
\_\_\_\_\_ (Print)

Title \_\_\_\_\_ Date \_\_\_\_\_

***All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.***

**RETURN COMPLETED FORM TO:**

**Department of Health and Human Services**  
**Medicaid Provider Enrollment**  
**P.O. BOX 8809, COLUMBIA, S.C. 29202-8809**  
**FAX (803) 699-8637**